NOTICE OF INDEPENDENT REVIEW DECISION

Date: August 13, 2003

RE: MDR Tracking #: M2-03-1227-01
IRO Certificate #: 5242

_____ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to _____ for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

_____ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by an Orthopedic Surgeon physician reviewer who is board certified in Orthopedic Surgery. The Orthopedic Surgeon physician reviewer has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for a determination prior to the referral to for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

Clinical History

The claimant has chronic back pain following an alleged work injury that occurred on ___. The claimant described pain as broad based across the lower back in a clinic note dated 4/11/02. EMG/NCV study report is normal. MRI report dated 3/14/02 indicates preservation of disc height at L4/5 and minimal decreased disc height at L5/S1 and changes consistent with mild degenerative disc disease at L5/S1. A discogram failed to show contrast within the anatomic disc bulge at L4/5 and L5/S1. The claimant had a different pain response at the 2 anticipated surgical levels of the discography. The claimant reported back pain and left hip pain at the L4/5 level. The claimant reported back pain, hip pain and thigh pain at the L5/S1 level.

Requested Service(s)

Decompression/posterior lumbar interbody fusion/posterior lumbar fixation and fusion at L4/5 and L5/S1.

Decision

I agree with the insurance carrier that the requested intervention is not medically necessary.

Rationale/Basis for Decision

Discography is a controversial test that can demonstrate anatomic abnormality in asymptomatic people and subjective response can be widely skewed particularly with psychological issues. Discography is not a primary diagnostic tool, but a confirmatory study in the presence of an established diagnosis of a significant disc condition when spinal fusion is anticipated. There is no documentation in this clinical setting of significant disc pathology at L5/S1 or L4/5 to indicate the medical necessity of fusion. Furthermore, the claimant's subjective response at the 2 anticipated surgical levels varies significantly.

There is no documentation of a true concordant pain response at the L4/5 and L5/S1 levels to indicate the medical necessity of surgical fusion in the absence of significant disc pathology at L4/5 and L5/S1 levels.

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing.

If disputing a spinal surgery prospective decision a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within **10** (ten) days of your receipt of this decision (20 Tex. Admin. Code 142.5(c)).

If disputing other prospective medical necessity (preauthorization) decisions a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision (28 Tex. Admin. Code 148.3).

This Decision is deemed received by you 5 (five) days after it was mailed (28 Tex. Admin. Code 102.4(h) or 102.5(d)). A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Workers' Compensation Commission, P.O. Box 40669, Austin, Texas, 78704-0012. **A copy of this decision should be attached to the request.**

The party appealing the decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute (Commission Rule 133.308 (t)(2)).

This decision by the IRO is deemed to be a TWCC decision and order.